HIV/AIDS STRATEGY

2001 – 2005

USAID/MALI

October 2000

Procurement Sensitive Information

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ACRONYMS

ACDI	Canadian International Development Agency
APE	Associations Parents-Elèves (Parents/Teachers Association)
AZT	AKA Retovir, AKA Lidovudine
CDC	Centers for Disease Control and Prevention
CNIECS	Centre National pour l'Information, l'Education et la Communication en Santé (National Center for Information, Education and Communication in Health)
CSP	Country Strategy Plan
CSW	Commercial Sex Worker
DG	Democratic Governance Strategic Objective, USAID/Mali
DHS	Demograhic and Health Survey
ECOWAS	Economic Community of West African States
EU	European Union
GRM	Government of the Republic of Mali
HIV/AIDS	Human Immune-Deficiency Virus / Acquired Immune Deficiency Syndrome
IGA	Income Generating Activities
IEC	Information, Education and Communication
InfoComm	Information and Communication Strategic Objective, USAID/Mali
ISBS	Integrated STI/AIDS Prevalence and Behavior Survey
KAP	Knowledge, Aptitude and Practice
MOH	Ministry of Health
MTCT	Mother-To-Child-Transmission
NCAP	National Committee for HIV/AIDS Prevention
NGO	Non-Governmental Organization
OR	Operational Research
PASA	Participating Agency Services Agreement
PLWHA	People Living With HIV/AIDS
PMT3	Plan à Moyen Terme 3 (National 5 Year HIV/AIDS and STI Strategic Plan, Phase 3)
PNLS	Programme National de Lutte contre le SIDA (National Program for HIV/AIDS Prevention)
PSAMAO	Prévention du SIDA sur les Axes Migratoires de l'Afrique de l'Ouest (Regional HIV Prevention Migrant Initiative)
PVO	Private Voluntary Organization
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific & Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

I. Dimensions of the Problem

The true magnitude of the HIV/AIDS epidemic in Mali is assuredly greater than that reported by the Government of the Republic of Mali (GRM). The existing statistics are alarming, but it is difficult to draw any conclusions about the trends of the HIV/AIDS epidemic in Mali since there is no reliable HIV surveillance system (a gap USAID is addressing). Though dated and underestimated, the statistics reported by the GRM include:

- HIV prevalence rate in urban areas ranges from 4%* in low-risk groups, to 44.7% in high-risk groups (Preliminary Integrated STI/AIDS Prevalence and Behavior Survey (ISBS) Mali 2000).
- 89,000* adults and children are currently living with HIV
- 44,000* adult and child AIDS cases have occurred since the beginning of the epidemic
- 40,000* adults and children have died of AIDS since the beginning of the epidemic

A. Women and HIV/AIDS

The June 2000 (end 1999 data) UNAIDS report estimates that there are currently 53,000 women between 15-49 years old living with HIV. Among sex workers in Bamako, the HIV prevalence rate rose from 39% in 1987 to 56% in 1995. HIV prevalence rates among sex workers in other regions range from 16% to 74%. In Bamako the HIV prevalence rate among antenatal clinic attendees increased from 1% in 1987 to 4% in 1994.

B. Children, Youth and HIV/AIDS

5,000 Malian children under age 15 are reported to be living with HIV/AIDS. Malian youth under age 25 represent two-thirds of the population and are the age group most vulnerable to HIV infection in terms of future economic growth and long term social impact. This group is critical to the political stability and economic viability of Mali as a new and still evolving democracy. Children of people living with AIDS may have additional demands on them to care for sick family members or contribute to the family income, and/or may need to drop out of school. It is clear that AIDS orphans are in need of financial, social and medical support, though we do not presently have statistics regarding the number of children orphaned due to AIDS.

C. Socioeconomic Effects of HIV/AIDS

Significant seasonal migration of agricultural workers to Senegal, Côte d'Ivoire and France during Mali's off-season could have a serious impact on the spread of HIV in

* GRM estimates.

Mali in the coming years, particularly migration to and from Côte d'Ivoire, which has the highest HIV prevalence rate in West Africa.

Many studies conducted in Mali have shown awareness and knowledge among different population groups concerning the means of transmission and prevention of HIV/AIDS. According to the 1995-1996 Demographic and Health Survey (DHS), 24% of women and 45% of men mentioned the condom as an HIV prevention method. However, the rate of condom use is extremely low, and contrasts with disease prevalence data showing relatively high rates of sexually transmitted infections (STI) in Mali. The number of AIDS patients seeking counseling and treatment from the few specialized centers operating in Mali has been growing.

Socioeconomic disparities between women and men in Mali increase women's vulnerability to HIV, in addition to women's greater biological susceptibility to HIV infection. Only 23% of women (compared with 39% of men) are literate, and female enrollment in primary and secondary schools is consistently lower than male enrollment. In general, women suffer from greater poverty due to lack of access to critical resources such as land, credit, extension services, and technology. This, in turn, limits their access to health and social services; and leads some women to sex work as a means of survival.

Adolescents are particularly vulnerable to HIV infection due to high-risk behaviors such as multiple sex partners and drug and alcohol use. Young women in particular are vulnerable due to early initiation of sexual activity and inability to negotiate/deny sexual advances. By age 16, 50% of women are either married or sexually active. In addition, 49% of rural women 15 to 19 years old have had at least one child. While knowledge of HIV/AIDS among adolescents is high (>80% females, >90% males), knowledge of STIs is considerably lower, and behavior related to condom use lags even further behind, especially among females (12%, vs 50% males condom use, 15-19 year olds).

In general, vulnerability to HIV/AIDS in Mali is related to cultural factors and migration.

1. Culture/Religion

- Inability of women to successfully negotiate condom use and promote fidelity with husbands/partners.

- Migration, which results in the loss of one's traditional family, social structure and norms, and places Malians (especially young Malians) at greater social risk.

- Practices mandating marriage among in-laws upon death of a spouse (levirat and sororat).

- Polygamy, and multiple sexual partners.

- Denial that AIDS exists or poses a threat.

- Persistent and highly prevalent female genital mutilation (FGM) practices.

- Perceived prohibitions on condom use.

2. Migration

Malians migrate within and outside of Mali to areas with higher HIV/AIDS prevalence. These seasonal migrations occur at certain times of the year, usually corresponding with the end of the agricultural season. Malians travel to visit family members in other countries and to find off-season work; residents of neighboring countries travel in and out of Mali on the international highways for similar reasons. HIV infected individuals traveling back to their villages from bordering countries (especially those with high rates of HIV/AIDS) and those traversing Mali from other parts of West Africa represent an important link in the spread of the epidemic to rural/low prevalence populations in Mali. The migration rate among high-risk groups is as much as 52%, including non-Malians (Preliminary ISBS Mali 2000).

D. National Response

The national response of the GRM has been weak so far, mainly due to poor management and leadership in the Ministry of Health (MOH) unit responsible for STI/HIV (Programme National de Lutte Contre le SIDA, or PNLS), and continued insistence from that unit that the epidemic has stabilized. However, recent changes in Ministry (Minister) and PNLS leadership bode well for the future.

In December 1999 PNLS developed its third HIV/AIDS Strategy (for the period 2000-2004). This strategy, referred to by its French acronym PMT3, delineates ten new objectives:

1. Promote a multi-sectoral response to HIV/AIDS through the active participation of political and civil society leaders at all levels (government institutions and community organizations).

2. Promote behavior change among high risk groups and the general population that decreases the risk of HIV infection;

3. Improve the quality of life of people living with HIV/AIDS (PLWHA).

4. Decrease/minimize mother-to-child transmission (MTCT).

5. Ensure STI diagnosis and treatment in all health facilities.

6. Alleviate the burdens of the impact of HIV/AIDS on families and communities.

7. Develop standards and laws that respect the dignity and rights of infected persons.

8. Expand health coverage and develop local and community capacity (reduce the burden on health system).

9. Ensure blood transfusion safety.

10. Collect and disseminate epidemiological data on a) the general population; b) vulnerable groups; and c) the impact of the HIV/AIDS epidemic in urban and rural areas.

Indicators have been identified by PNLS for each of the PMT3 objectives.

E. Favorable factors in Mali

1. Presumed still (relatively) low prevalence in the general population.

2. Political commitment at the level of the President, who is also currently President of the Economic Community of West African States (ECOWAS).

3. Commitment from a new MOH Minister (February 2000) and PNLS Director (June 2000).

4. An extensive network of Malian and international private voluntary organizations (PVOs) and local non-governmental organizations (NGOs) which are very active and well integrated with groups at risk for STI/HIV.

5. The ISBS system presently providing data.

II. What USAID is Doing Now

USAID/Mali funds the Centers for Disease Control and Prevention (CDC), local non-governmental organizations (NGOs), and the MOH division responsible for STI/HIV prevention. STI control is a vital strategy for managing the spread of HIV/AIDS. Thus USAID's program emphasizes national STI control, prevention, and STI/AIDS surveillance. Major activities address regional level capability to support STI/AIDS service delivery needs, including the development of technical and pedagogical skills to train service delivery providers in STI case management, and Mali-specific STI treatment approaches and counseling. CDC is working closely with the PNLS to implement STI syndromic training and supervision, referral services, surveillance, operational research and other activities designed to improve STI health-seeking behaviors and clinical care.

In addition to public institutions, however, CDC will also initiate activities to improve STI care at semi-private and private clinics in the same vicinity, which often see as many or more STI patients than pharmacies and private medical practices. CDC will examine available data concerning STI health seeking behavior and conduct rapid assessments of local STI care situations in order to determine where to institute improved STI care. Data

sources include data from the Canadian Aid Sikasso-based project (SIDA II), the ISBS study and the DHS+ 2000.

Commercial Sex Worker (CSW) STI Services: CDC will be working with NGOs in Mali that offer STI services to commercial sex workers to develop improved STI care for this population. In addition to supporting NGOs' current STI syndromic treatment services, CDC plans to expand NGO on-site laboratory capacity to allow a minimum amount of laboratory confirmation for STIs. In addition, NGOs will be able to use the STI reference laboratory in Bamako for further laboratory confirmation of disease.

National level STI and HIV/AIDS diagnostic capability is also being developed at the National Institute for Public Health. An ISBS system has been established through USAID's funding to CDC. This ISBS system, which will eventually be in place nationally, monitors and tracks STI and HIV/AIDS prevalence and high-risk sexual behavior in selected sentinel groups on a regular basis. The first survey began in April 2000 in four cities (Bamako. Mopti, Sikasso and Segou), and preliminary data is now available. The information will be used to target prevention programs, identify specific behaviors in need of change, and provide indicators of success and persistent problem areas.

STI/HIV information, education, and communication (IEC) activities are aimed at the general population as well as high-risk groups. These are most effectively implemented through international Private Voluntary Organizations (PVOs) and local NGOs. USAID's NGO programs promote community-based marketing of condoms in collaboration with the existing social marketing approach and conduct STI/AIDS awareness and prevention activities at the community level.

III. Objectives and Activities

The **overall objective** of USAID/Mali's strategy for HIV/AIDS will be to divert the emergence of a crisis HIV/AIDS epidemic **by targeting high risk groups/high transmitters** and promoting behavior change among those most at risk and the general population. In a concerted effort to develop an enabling environment nationwide, national level and community leaders and decision-makers will be targeted; and PNLS will be assisted with surveillance, program development, management and technical skills. At the operational level, high and medium risk groups and high prevalence areas will be targeted with the objective of decreasing HIV/AIDS transmission. Interventions will be based on approaches tested and applied elsewhere, i.e., specialized STI case management services, including etiological testing; voluntary counseling and testing centers, including referrals; and high risk establishment-based programs. People living with HIV/AIDS (PLHWA) will be targeted with the aim of preventing/decreasing HIV/AIDS transmission including mother-to-child transmission (MTCT), and of preventing/decreasing opportunistic infections. These targeted interventions will be **complemented by strategy elements** aimed at developing **PNLS capacity**, and at reaching the **general population**, including the special needs of youth, to promote

positive reproductive health behaviors. Such interventions include education campaigns, behavior change interventions, STI service strengthening, and school-based (sexual) health education.

The USAID/Mali HIV/AIDS Strategy period is five years, 2001 – 2005. An assessment of strategy implementation will be conducted at the end of implementation year two, i.e., in late 2002. At that time, the strategy will be revised and expanded, to complement USAID/Mali's overall new CSP directions. Strategy elements of longer-term support to other sectors, including education, will be more fully developed in the subsequent phase.

A. National Level

1. Objective: Create an enabling political environment for an effective, multi-sectoral program response to HIV/AIDS.

a) Target: National, regional, and community level decision-makers.

b) Purpose: Expand awareness of and commitment to HIV/AIDS programming needs.

c) PMT3 Linkage: PMT3 objectives 1 and 10 per section I.D (National Response).

d) Rationale: HIV/AIDS program implementation in Mali has been characterized by a lack of adequate responses at all levels, persistence of high-risk behavior and lack of coordination. There is also a lack of awareness of the economic and social consequences of HIV/AIDS, and high vulnerability due to the cultural and religious factors hampering behavior change.

   In Senegal and Uganda, for example, advocacy programs targeting political, religious,

- Present advocacy materials to appropriate individuals and partners.

- Promote dialogue on multi-sectoral HIV task force creation. Target ministries include Rural Development, Education, Decentralization, Woman, Child and Family, Youth and Sports, Defense, Industry, Finance, Social Action and Labor. The National Assembly, private sector organizations and civil society will also be targeted in this effort.

- Develop advocacy capabilities within PNLS, and through the establishment of core groups of trainers from public and private sectors, including NGOs.

- Implement group sensitive advocacy programs targeting leaders at the national, regional and community levels. In Mali, in addition to formal political, religious and community leaders, it will be necessary to target leaders of traditional associations as well, e.g., the hunters' associations, traditional healers' associations, feticheurs ("fetishers"), traditional chiefs, and women's and youth associations.

f) Funding source: USAID HIV/AIDS account

g) Mechanism: Field Support

h) Anticipated Results/Indicators: Multi-sectoral program response as measured by:

    - Number of
        - national level institutions
        - regions
        - communes
        - organizations (unions, religions, etc.)
        - public/private enterprises

with HIV/AIDS action plans and implementing HIV/AIDS activities.

2. Objective: Develop PNLS capability to assume leadership and coordination of HIV/AIDS prevention and control activities

a) Target: PNLS staff, national and regional levels.

b) Purpose: Support MOH's efforts to energize PNLS leadership and strengthen institutional capacity.

c) PMT3 Linkage: PNLS reorganization plan, per PMT3 document.

d) Rationale: The management of the national HIV/AIDS program needs to be strengthened. Weak leadership, weak management capacity, lack of coordination and

decentralization, denial regarding the magnitude of the epidemic, and lack of attention to a multi-sectoral approach are factors to be addressed.

e) Activities:

- Promote management reorganization at PNLS, to emphasize core/senior staff coordination functions and support through technical subcommittees.

- Assist MOH in the organization of a national committee for HIV/AIDS with membership from the public and private sectors, NGOs, the military and donors. The committee will function as a steering committee, as described in the PMT3 document.

- Assist the MOH in efforts to revitalize decentralized/regional PNLS groups for HIV/AIDS activities.

- Provide short-term training, ongoing TA and site visits to other successful PNLSs (e.g., Senegal, Uganda, and Cote d'Ivoire) to Malian PNLS managers.

- Promote the establishment of a HIV/AIDS documentation center: assess information needs for potential technical and general population clients, identify appropriate organizational locations for document centers, and seek donors/sponsors for such centers.

- Establish and institutionalize HIV/AIDS sentinel surveillance. This surveillance system will target pregnant women, blood donors, STI patients and/or tuberculosis (TB) patients to complement the biannual ISBS for high and medium risk groups (CSWs, truck and bus drivers, bus station attendants ("coxeurs"), female ambulatory vendors, bar managers and clients, factory workers, and maids). (This represents a high priority for the GRM and donors as a prerequisite for HIV/AIDS program design, management, monitoring and evaluation).

- Increase surveillance among TB (and other AIDS-related diseases) patients.

- Establish testing capabilities related to surveillance and VCT, including infrastructure and laboratory equipment.

- Develop PNLS advocacy capabilities, using up-to-date data and situational analyses.

f) Funding source: USAID HIV/AIDS account; CS/Basic Education Account.

g) Mechanism: CDC/PASA.

h) Anticipated Results/Indicators:

- Line ministry committees functional.
- National coordinating committee (PNLS-level) functional.

- Regional PNLS coordinating committees functional.
- Respective level work plan monitoring and oversight by PNLS.
- Sentinel surveillance functional.
- Surveillance-related testing capabilities established.
- Documentation center(s) established.

3. Objective: Increase knowledge of and promote positive RH behaviors (IEC).

a) Target: General population.

b) Purposes: Reach the general population with effective prevention strategies; reach targeted high/medium risk groups with information on effective prevention strategies; and promote the use of services which deal with HIV/AIDS counseling, referral and treatment.

c) PMT3 Linkage: PMT3 objective 2 per section I.D.(National Response).

d) Rationale: IEC programs targeting increased knowledge and behavior change are critical for the success of HIV/AIDS transmission prevention. The IEC programs will use DHS 2000/01 data to complement extensive efforts already undertaken in this area since the '95/96 DHS, to ensure high levels of knowledge across all segments of the general population. DHS and ISBS data will be used to promote use of referral and counseling services, and to promote safe practices (sexual, medical and cultural) and positive behavior change.

e) Activities:

- Based on the ISBS and DHS results, the IEC programs will develop communication strategies, media avenues and content taking into account diverse segments of the population, and cultural and religious practices influencing the transmission of HIV/AIDS. Media such as theater, marionettes, songs, proverbs, dance, and story telling will be used. The IEC program will build heavily on the existing network of community organizations (including NGOs and radio stations), and will continue to work closely with USAID/Mali's Information and Communications SO (InfoComm) activities. The IEC approach and messages will be revised based on KAP and other studies. Peer education programs for high/medium risk groups will be expanded (see III.B.1, and III.C.2).

f) Funding Source: USAID HIV/AIDS account.

g) Mechanism: PVOs/NGOs; USAID-MOH direct (National Center for IEC in Health/CNIECS).

h) Anticipated Results/Indicators:

- Increased awareness of HIV/AIDS counseling/treatment service availability.
- Increased knowledge of STI/HIV/AIDS prevention methods.
- Increased condom use among targeted groups..
- Increased use of STI case management service delivery.
- Increased VCT use.

B. Operational Level

1. Objective: Contain and decrease HIV/AIDS transmission among high-risk groups.

a) Target: High and medium risk groups (highly mobile populations) - CSWs, truck and bus drivers, bus station attendants, female ambulatory vendors, bar clients, factory workers, and maids; and relevant gatekeepers of these groups.

b) Purpose: Contain the spread of HIV/AIDS to the general population.

c) PMT3 Linkage: PMT3 objectives 2 and 5 per section I.D. (National Response).

d) Rationale: At Mali's (presumed) stage of prevalence, it is necessary to target core urban high-risk groups to limit further spread of HIV/AIDS to the general population.

e) Activities:

- STI case management: STIs are co-factors of HIV transmission and are usually prevalent in high-risk transmitters. STI case management has proven effective in decreasing HIV transmission. In Mali where the general STI prevalence is relatively low, **targeted -** as opposed to generalized **-** syndromic approach interventions will be emphasized. These will be **complemented** by the development of diagnostic methods and capabilities, including counseling/referrals, in all primary and secondary health centers (general knowledge and skills level to be achieved among all health providers).

  Site identification for targeted STI case management in model clinics will be based on ISBS results. The program will establish model clinics for specialized STI management, treatment, monitoring and referral in the private sector (and, ultimately, in the public sector) targeting the appropriate high and medium risk groups.

  In model clinics targeting high-risk groups, it will be necessary to combine the syndromic approach with minimal routine etiological management. The program will build on existing centers servicing high risk groups and expand into new model clinics as they are established; and will develop institutional capabilities for on-site laboratory work, OR and monitoring. (See III.C.1. for discussion on operations research (OR).)

Funding source: USAID HIV/AIDS account; funding for drugs TBD/sought.

Mechanism: CDC/Participating Agency Service Agreement (PASA) (NGOs, including Danayaso) and/or USAID-MOH direct (PNLS) support.

- Voluntary Counseling and Testing (VCT): VCT services provide the opportunity for individuals to know their serostatus. These services are linked to HIV/AIDS program efforts in that they enable individuals to take actions and make decisions to mitigate their condition (seropositive) or to stay negative. Every individual should have the opportunity to know his/her serostatus; offering VCT services to high-risk transmitters should contribute to behavior change, and thus decrease transmission of HIV to the general population.

  The demand for VCT services among the general population is difficult to ascertain at this time, while 95% of high/medium risk respondents surveyed in the ISBS expressed the desire to know serostatus.

  VCT activities will build on the few existing services, and will extend to organizations at the regional, district and community levels. It is currently anticipated that VCTs in 3 regions plus Bamako will be established with the assistance of CDC; NGOs may ultimately develop additional services. Interventions will include training of trainers in pre- and post-test counseling; provision of HIV testing kits (with an emphasis on rapid testing); and training of counselors who will refer patients to health centers for STI/HIV/AIDS services or treatment of opportunistic infections, and/or to community support services. Individuals from the GRM's social welfare program will be associated in all counseling trainings. A system for communications between the VCT service organizations and referral health centers and/or community support services will be developed. Tracking systems will be established.

  - IEC through peer education will be pursued (see "Peer Education" below, and III.C.2).

  - Condom social marketing: See III.C.3.

  Funding source: USAID HIV/AIDS and DA Pop accounts; other organization/donor funding will be sought for provision of rapid tests.

  Mechanism: CDC/PASA; PVOs/NGOs.

- Focus on high risk establishments and geographic locations: Specific areas with a high potential for transmission risk factors - mining sites, factories, borders, and bus stations, for example, necessitate integrated approaches for prevention. Advocacy programs will be created to target businesses, unions, private sector leaders (e.g.,

Chamber of Commerce), and local youth and women associations. Peer education and condom promotion activities will be implemented.

With co-funding from factory and mine owners, factories' and mining sites' health and social centers will be upgraded via staff training in STI case management including counseling, provision of rapid test kits, laboratory equipment and drug supplies. VCT centers will be created to assist workers who are infected or affected by HIV/AIDS.

Funding source: USAID HIV/AIDS account.

Mechanism: PVOs/NGOs; CDC/PASA (including subcontracting with local and regional organizations).

- Cross-border activities with neighboring countries and programs: Building on the approaches and tools developed and implemented by FHA's Regional HIV Prevention Migrant Initiative (PSAMAO) in Côte d'Ivoire, Burkina Faso and Togo, the following activities are proposed toward an expansion to Mali.

  - Baseline research: A baseline knowledge, attitudes and practice (KAP) study (determinants of risk behaviors) among truckers and CSWs would be conducted on the Bamako-Zégoua, Bamako Koury and Bamako Kidira axes as well as one on a control axis to be identified.

  - Mass media campaign: Regional radio and TV spots will be adapted to the Malian context and aired; in particular, the radio spot would be translated into Bambara. Billboards with a pack shot of Protector (the national socially marketed condom) would be produced and installed in the appropriate Malian border towns, as well as in those of neighboring countries.

  - Peer-education: Peer-education activities will be pursued in border areas, in locations as defined by the ISBS and the July, 1999 Castle study ("Identification of Medium Risk Groups for ISBS Study in Mali"). Promotional materials will be used to motivate the peer-educators and generate enthusiasm among the targeted populations. Efforts will build on existing experience and materials (e.g., flipcharts and pamphlets already developed in Dioula for use in Burkina Faso and Côte d'Ivoire; technical assistance from a NGO already involved in PSAMAO peer-education); and will promote high risk group self management and implementation.

  - Condom distribution: Peer-educators selling condoms obtained through the national social marketing program (The Futures Group/Mali, funded by USAID) will be complemented by addressing gaps, if any, in the commercial distribution system in these areas.

Funding source: USAID HIV/AIDS and DA/Pop accounts; PSAMAO.

Mechanism: Private Voluntary Organizations (PVO)/NGOs; on-going TA contractor.

f) Anticipated Results:

- Increased condom use among targeted groups.
- Increased STI case management capabilities, public and private service delivery sites.
- Increased use of STI case management service delivery.
- Increased VCT availability and use.
- Decreased prevalence of diagnosed STIs, men and women.
- Increased number of high-risk establishments/private groups working in HIV/AIDS.

2. Objective: Improve access to and quality of care and support for people living with HIV/AIDS (PLWHA) and their families including orphans.

a) Target: PLWHA.

b) Purposes: Provide opportunities for psychosocial support; promote positive behaviors; and prevent/decrease opportunistic infections of HIV/AIDS (including TB) and MTCT.

c) PMT3 Linkage: PMT3 objectives 3 and 4 per section I.D. (National Response).

d) Rationale: Care and support to PLWHA should decrease the occurrence of opportunistic infections and improve quality of life. Treatment of HIV positive pregnant women should decrease the rate of MTCT. Addressing issues of denial, stigmatization and discrimination will contribute to positive health care seeking behavior.

e) Activities:

- A system for referring PLWHA to selected health centers (model clinics) will be developed. In each region, selected public and private health centers will be strengthened to respond to the needs of PLWHA through training for counseling and psychosocial support; provision of drugs (cotrimoxazole and AZT); and support for income generating activities. Capabilities in data collection and use for monitoring and evaluation, and in OR (e.g., for MTCT) will be developed (see further description in OR under "Support Strategies" section, below).

- PLWHA associations will be strengthened through training in leadership, organizational capacity development, income generating activities (IGA), IEC, counseling, etc., mentoring and development of networking capacities. PLWHA

associations will be encouraged and supported to conduct intensive advocacy activities/awareness raising in all regions and with diverse groups of leaders and communities according to the demand. The project will build on and extend the few existing experiences of PLWHA associations in terms of orphan and widows support. Efforts to promote community-based activities (see III.C.5) will complement this element.

- Screening of TB patients for HIV/AIDS serostatus will be conducted at TB clinic(s) and health centers, for the purpose of establishing an appropriate treatment regimen for TB patients co-infected with HIV/AIDS.

f) Funding source: USAID HIV/AIDS account. Funding for drugs, diagnostic equipment and reagents will be sought from other donors through the MOH.

g) Mechanism: NGOs through CDC, and MOH.

h) Anticipated Results/Indicators:

- Increased number of PLWHA who benefit from specialized/model clinic services.
- Increase in number of seropositive pregnant women who benefit from anti-retroviral treatment.
- Number of income generating activities launched.

C. Support Strategies

This section outlines: emphases that support various elements of the strategy as presented above; and aspects of USAID/Mali's on-going portfolio that address HIV/AIDS.

1. Objective: Ensure the availability and use of accurate and up-to-date data on HIV/AIDS for program implementation decisions.

a) Target: Decision makers, managers, service providers.

b) Purpose: Promote the ability to monitor and evaluate HIV/AIDS interventions, and make appropriate program adjustments.

c) PMT3 Linkage: PMT 3 Objective 10.

d) Rationale: Accurate data and information must be available to guide programming decisions and service delivery elements.

e) Activities **(new)**:

- STI algorithm validation and antibiotic sensitivity: STI algorithms need to be periodically validated and updated so that they correspond with current STI etiology, changing drug availability, health seeking behaviors, and antibiotic resistance.

- Determinants of risk behaviors: ISBS data must be complemented by in-depth studies of determinants of risk behaviors among particular groups in order to design more specific targeted interventions. This will require participation by the public (CNIECS) and private (PVOs and NGOs) sectors.

- Rapid/voluntary testing validation: Rapid/voluntary testing approaches are effective in increasing access to VCT centers (Botswana and Malawi experiences). Before introducing this approach to counseling/testing there is a need to study the effectiveness of using rapid tests in VCT centers in the cultural and social contexts of Mali.

- MTCT baseline study: There is no recent data on MTCT in Mali.

- Baseline KAP for VCT center development: Input from potential users of VCT centers is needed before proceeding with centers' development.

- "Youth ISBS": It is important to understand where young females can be accessed for HIV prevention, particularly in light of low female school enrollment. As such, ISBS Mali data on domestic servants and ambulatory sellers needs to be supplemented with similar data (risk behaviors and disease prevalence) on in- and out-of-school females and young women (approx. 15-24 year olds) seeking pre-natal care in more rural areas. Data for young women in school (grades 5 and up) will also be sought.

- Biomarkers incorporated into the Demographic and Health Survey+ (DHS): The ISBS study will provide data on behaviors and STI/HIV prevalence rates among high and medium risk groups. Prevalence data on HIV in the general population is needed to refine a national strategy and approaches specific to Mali's need. The use of already planned manpower and logistics for the DHS+ to include collection of blood spot samples for HIV prevalence is cost-effective and will provide information for all regions in 2001. (Note: Implementation of this activity is being reviewed by the MOH. It is conceivable that the MOH will prefer implementing a separate HIV/AIDS prevalence study.)

- ISBS and sentinel surveillance -- see section III.A.2.

f) Funding source: USAID HIV/AIDS account.

g) Mechanism: CDC PASA; NGOs (determinants of risk behaviors; baseline KAP survey for VCT center development).

h) Anticipated Results:

- Relevant data for programmatic and clinical decision-making is routinely available.
- KAP data used to guide IEC approaches and content.
- KAP data used to guide VCT center development and approaches.

2. Objective: Decrease vulnerability of HIV infection among adolescent populations.

a) Target: In- and out-of-school adolescents (10-25 year olds).

b) Purpose: Provide adolescents with the knowledge and skills needed to practice positive RH behavior.

c) PMT3 Linkage: Objectives 2 and 8.

d) Rationale: Adolescents and young adults are particularly vulnerable to STIs and HIV/AIDS infection. As a group, youth tend to be uninformed or misinformed about sexuality and reproductive health, and reluctant to take action to protect themselves. Youth tend to exhibit high-risk behaviors (multiple sex partners, drug and alcohol use), and may not consider themselves at risk of infections. Youth frequently lack support from others to discuss RH concerns and problems; and often cannot afford or do not have easy access to contraceptives and health services. Socioeconomic and cultural factors may also hamper young people's ability to make informed and responsible decisions to safeguard their health.

e) Activities:

- **(on-going)**: Life skills curriculum in primary schools (public and community schools): Life skills curricular modules and Pedagogie Convergente materials (textbooks, teachers guides, visuals), including reproductive health and nutrition, are currently being developed for introduction into all primary school (public and community) curricula nationwide. With the Ministry of Education's 10 Year Plan (PRODEC) guiding implementation to begin at lower grades and expand, over time, to higher grades, curricular content for the higher grades will increasingly emphasize RH, including HIV/AIDS.

- **(on-going, and to be expanded)** Peer educators: Over 3,500 peer educators have been trained to sensitize and inform fellow youth on reproductive health issues, including real vulnerability to infections, and options that may exist. These peer educators serve as first contact counselors and sources of FP information and commodities (pills and condoms), and refer clients to health services in appropriate situations (some peer educator programs have their own clinics for youth referrals).

Peer educators work primarily (not exclusively) in out-of-school settings. Hundreds of thousands of youth have been reached directly and/or through mass media.

- **(on-going)** Health services/peer educator linkages: A peer educator curriculum has been developed and serves as the curriculum for all peer educator training in Mali (MOH also involved). Peer educator training is on going among implementing NGO programs. A curriculum on reproductive health services for youth for **public health service provider** training has been developed by the MOH, based on the peer educator curriculum and experiences. Linkages between NGO peer educators and MOH service delivery points to receive peer educator referrals are being established.

- **(on-going)** Affordable models of STI drug availability for youth: A situational analysis of STI service availability for adolescents, and design and evaluation of three different models for improving access to STI drugs and services will be conducted. Possible models include youth centers, school-based and NGO-based programs. For the out-years of this strategy period, focus will shift to implementation and scaling-up.

  - **(new)** "Youth ISBS" - see III.C.1.

f) Funding source: USAID CS and HIV/AIDS accounts.

g) Mechanisms: On-going technical assistance (TA) contractor (life skills modules and STI drug delivery models); NGO partners (peer educators); TA contractor/NGO partner collaborative efforts with MOH (health services/peer educator linkages).

h) Anticipated Results:

- Increased knowledge of RH and HIV/AIDS preventive practices among adolescent groups.
- Increased access to RH/HIV/AIDS services for adolescent groups.
- Increase in referrals for RH/HVI/AIDS services for adolescents.
- Increased contraceptive (condom) use among adolescents.

3. Objective: Increase condom availability and use.

a) Target: General population; targeted high and medium risk groups.

b) Purpose: Promote responsible reproductive health behaviors.

c) PMT3 Linkage: Section 5, Priority Intervention Areas.

d) Rationale: Condom use prevents HIV/AIDS infection. Condom use needs to be disassociated from prostitution.

e) Activity **(on going)**: Social marketing: Distribution of socially marketed products is via the private sector and through private distributors, including peer educators. Approximately 12,000 condom sales points have been established; private outlets are being expanded. Information campaigns target high-risk groups, adolescents, and the general population. (It is estimated that the social marketing program contributes to at least 90% of CPR in Mali.)

f) Funding source: USAID DA/Pop account.

g) Mechanism: TA contractor; NGO partners.

h) Anticipated Results:

- Increased CYP and CPR, general population
- Increased CYP/condoms, high/medium risk groups and adolescents.

4. Objective: Promote long term contraceptive (condom) security.

a) Target: MOH FP planners and decision-makers.

b) Purpose: Ensure the long term availability of contraceptives, including condoms.

c) PMT3 Linkage: Section 5, Priority Prevention Areas.

d) Rationale: Use of condoms decreases the risk of STI and HIV/AIDS transmission. Condoms must continue to be widely available.

e) Activity **(on-going)**:

- Development and implementation of long term vision on contraceptive sustainability for Mali.

f) Funding source: USAID DA/Pop Account

g) Mechanism: Field Support

h) Anticipated Result:

- Action plan for long term contraceptive/condom security developed and being implemented.

5. Objective: Promote community-based activities.

a) Target: School teachers, parents, community leaders, community organizations (including Parent/Teacher Associations (APEs)).

b) Purpose: Involve the community in determining what HIV/AIDS interventions are relevant and how they are most appropriately implemented.

c) PMT3 Linkage: Section 4.2. Strategic Directions.

d) Rationale: The involvement of parents in determining when and how RH/HIV/AIDS is taught to their children is crucial to these activities actually taking place. Involving teachers in the development of such activities and association with parents helps ensure their acceptance of such functions.

e) Activities:

- **(new)** Promote contacts with all (public and community) school teachers, parents and community leaders, to define what elements and/or conditions of RH/HIV/AIDS education are appropriate; facilitate sessions for public dialogue.

- **(on-going)** Local NGO and community organization capacity development (Democratic Governance (DG) linkage).

f) Funding source: USAID CS/Basic Education account; DA account.

g) Mechanism: NGOs.

h) Anticipated Results:

    - Increased awareness/decreased stigmatization around HIV/AIDS
    - Community action plans developed/implemented.

IV. Other donor activities

Based on a review of other donor activities and programming, implementation of this strategy will provide significant impetus to the HIV/AIDS efforts in Mali, and position USAID as the lead donor in support of PNLS/Mali. As a member of the National Coordinating Committee on HIV/AIDS prevention under the aegis of the PNLS, USAID will work collaboratively with partners and donors to plan and executive activities in support of Mali's PMT3.

1. EU: Blood transfusion safety (transfusion center renovation, testing equipment and kits), support to MOH IEC programs.

2. French Cooperation Agency: Support to PLWHA programs. Activities include provision of drugs, testing materials, funding of IGA to support orphans and widows; plans for establishment of other such centers in three other regions.

3. UNDP: Regional workshops on "HIV and Development" (9 regions); micro-projects (five) aimed at reducing the socio-economic burden of HIV/AIDS; IEC (Sikasso and Mopti regions).

4. UNICEF: School based program: Activities include training of teachers and provision of 2000 booklets on STI and HIV/AIDS prevention to primary school students; organization and support to Students' Clubs leading advocacy programs; development of post literacy materials on HIV/AIDS.

   Support to PLWHA: Support PNLS for the development of norms and procedures for care and support to PLWHA; implementation of a drug distribution/cost recovery mechanism; program for breastfeeding mothers living with AIDS; support for the creation of Ethics and Law groups; program for prevention of HIV transmission in hospitals; epidemiological surveillance.

   IEC: Reproduction and dissemination of existing IEC materials; support to radio programs.

5. WHO: STI case management training; drugs for treatment of opportunistic infections; International HIV/AIDS Day; TA support to PMT3 through WHO/AFRO.

6. ACDI: STI management in Sikasso Region and two Bamako communes.

7. UNESCO: IEC targeting youth and women (regions of Kayes and the North).

8. IBRD: Equipment (additional information is forthcoming).

V. Summary of USAID-Supported Activities

A. CDC/PASA (on-going/in process)

1. PNLS management reorganization/capacity strengthening
2. Nationwide STI capabilities
3. Specialized STI clinic services
4. VCT services development
5. ISBS data collection/analysis
6. Sentinel surveillance
7. Laboratory testing capability and equipment
8. Monitoring/evaluation/OR
9. Documentation Center support
10. ISBS

B. NGOs via CDC/PASA (on-going/in process)

1. Specialized STI clinic services
2. VCT services establishment and delivery
3. High risk establishment-based programs
4. IEC
5. Counseling/support to PLWHA

C. USAID/MOH Direct (on-going)

1. Advocacy training/implementation
2. Management/capacity training
3. IEC development/promotional activities
4. Adolescent RH activities
5. Counseling training

D. NGO USAID Direct (new)

1. Determinants of risk behaviors
2. VCT baseline KAP
3. VCT establishment and delivery
4. IEC
5. Monitoring
6. Counseling/support to PLWHA
7. Cross border activities
8. Peer education, high/medium risk, adolescents
9. Community mobilization, APEs, schools and community leaders

E. Field Support

1. Advocacy **(new)**
2. Contraceptive security **(on-going)**

F. On-going USAID TA contractor and/or Cooperative Agreements (on-going)

1. School health programs (curricular modules and materials)
2. Social marketing
3. Contraceptive (condom) security
4. Local radio
5. STI drug availability
6. Best practices for reaching high risk groups for HIV/AIDS – dissemination activities

VI. Coordination and Management Mechanisms

Management of disparate activities addressing HIV/AIDS will continue to pose a challenge through the remainder of the current Country Strategy Plan (CSP), in light of complex mechanisms already in place, and personnel constraints. We have determined that an additional PSC health professional will be required to ensure that the demands of this urgent program are appropriately addressed.

Pieces of the USAID on-going and proposed program, and factors included for consideration, are as follows:

1. CDC/PASA (including NGOs through CDC) – CDC TA is physically located within the PNLS. Programmatically, close and regular work plan implementation planning and monitoring has been established, recently facilitated by the nomination of a new PNLS Director. CDC adheres to a regular schedule of up-date and/or informational meetings with USAID; USAID also participates in quarterly tripartite (PNLS/USAID/CDC) reviews, as well as in broader (i.e., other donor) program reviews called for by PNLS. USAID's role is to serve as bridge between specific CDC activities in support of PNLS, and those of other partners working on relevant STI/HIV/AIDS activities.

CDC is also initiating and will oversee the development and implementation of specialized service programs through local NGOs. The NGOs selected will already have demonstrated capabilities in these areas.

2. USAID/MOH Direct – There has been a long history of USAID/Mali direct financial support for implementation of specific program activities (trainings, studies, workshops, etc.) by MOH central and field services. While the amount of funding and emphasis on this mechanism has been diminishing over time, the mechanism remains in place for the foreseeable future, i.e., through the end of the current CSP; and at least allows for local cost funding of important activities. Specifically for STI/HIV/AIDS, USAID assumes responsibility for ensuring that annual USAID/MOH direct work plans are integrated with those of CDC for a) relevant CDC/TA technical input, and b) adequate and timely USAID funding availability for such activities; then monitors implementation of such activities with CDC and the PNLS, as described above. Once again, with the arrival of a new Director, coordination has been facilitated.

3. NGO USAID Direct -- USAID/Mali is issuing an Annual Program Statement (APS) for new activities as described in this strategy document. USAID anticipates awarding up to two Cooperative Agreements (rather than Grants) from applications submitted in response to this APS. The Agreements will be for a period up to two years, which will end by December 31, 2002. It is anticipated that the total amount of funding available under this APS is $4.0 million. Substantial involvement under the Cooperative Agreements shall include: approval of key personnel; USAID approval of yearly work plans; USAID monitoring of work plan achievements to ensure

complementarity with other USAID-funded programs and activities (1. other USAID partners (CDC, MOH, FS) and 2. the PNLS); and approval of the recipient's monitoring and evaluation plan.

4. Field Support -- As above, USAID will require FS program work plan integration with 1) other USAID partners (CDC, MOH, FS) and 2) the PNLS.

5. On-Going TA Contract and Cooperative Agreements -- Under routine CTO functions, USAID assures linkages between these and other partners, as appropriate.

Summary: **Coordination** of USAID's overall input for STI/HIV/AIDS activities will be under the aegis of the PNLS Director and staff. **Management** of USAID's overall input for STI/HIV/AIDS activities will be assured by USAID through unified work plan approval in support of the PNLS. USAID will serve as direct interlocutor with PNLS for management of unified work plan activities.

VII. Organizational Next Steps

Further elaboration of HIV/AIDS strategy elements and expansion into other sectors will logically be associated with the development of USAID/Mali's next CSP, 2003–2012. Once the new activities as defined under this strategy are underway, we will turn to consulting with other SOs, government, donors and other partners to outline elements, and vet and agree upon scope and emphases for USAID support. The assessment of this strategy (2001-2005), scheduled for late 2002, will contribute to the analytical basis.

The agreed-upon elements will be subsequently developed in a full HIV/AIDS strategy for the new CSP period.